

**STATE OF MAINE**

**BOARD OF**  
**CHIROPRACTIC LICENSURE**

**APPLICATION FOR LICENSURE**

**CHIROPRACTOR**



Department of Professional and Financial Regulation

Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689  
TTY/HEARING IMPAIRED 1-888-577-6690  
Office located at: 122 Northern Avenue, Gardiner, Maine

E-Mail: [voni.a.eames@maine.gov](mailto:voni.a.eames@maine.gov)

## APPLICATION INSTRUCTIONS FOR CHIROPRACTORS

### EXAMINATION OR ENDORSEMENT APPLICANT'S CHECKLIST OF THINGS TO DO:

- ☐ Application
- ☐ Application fee      \$50.00
- ☐ License fee \$225.00 on even numbered years, \$112.50 on odd numbered years
- ☐ Criminal background record check fee \$15.00
- ☐ Pre-Chiropractic Transcripts
- ☐ Official Chiropractic Transcripts
- ☐ Chiropractic Diploma
- ☐ National Board Scores - Parts 1, 2, 3, 4, and Physiotherapy
- ☐ Verification of licensure from all states you hold or have held a chiropractic license  
(if applicable)
- ☐ Two Certificates of Good Moral Character Form

**Payment of fees may be made in the form of a check or money order payable to Treasurer, State of Maine, VISA, MasterCard – (see credit card authorization form).**

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The Board of Chiropractic Licensure requires that all supporting documents and fees be submitted with the filing of your application. Your application will not be accepted if supporting documents and/or fees are omitted. Documents that have been modified or altered in any way will not be accepted. For National Board Scores, we will accept an unofficial transcript or a copy of the letter you received from the National Board of your successful passing of each part of the exam including physiotherapy.

If you are applying by endorsement you must provide the standards of your original licensure in the state where you are currently licensed. You must submit to the Maine Board the Laws and Rules of that State.

Once your application has been approved, a Jurisprudence exam will be mailed to you. This is a take home exam and must be returned to the Board within 20 days. Once all of the requirements are met, a license will be issued. **You cannot practice in Maine until you receive a Maine license.**

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be \$15.00 as of May 1, 2003.

**SPECIAL NOTICE:** Requirements and fees subject to change. Please contact the office for current requirements. The Board cannot accept any faxed documents, please send originals.



STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF CHIROPRACTIC LICENSURE  
35 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603  
FAX: (207) 624-8637 Hearing Impaired: 1-888-577-6690

JOHN ELIAS BALDACCI  
GOVERNOR

Office use only

Cash # \_\_\_\_\_

4180 1446 \$50  
4180 1421 \$225 or \$112.50  
4180 2619 \$15

ANNE L. HEAD  
DIRECTOR

## CHIROPRACTOR - Application

Application Fee: \$50.00      Original License Fee: \$225.00 even years  
\$112.50 odd years  
Criminal Background Check Fee (2619) \$15.00

### Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

### Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

<b>Name:</b>			<b>(Any other names used)</b>		
<b>Contact Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip Code:</b>	
<b>County:</b>			<b>Telephone #:</b>		
<b>Social Security #:</b>			<b>Date of Birth:</b>		

NAME AND LOCATION OF SCHOOL	DATE GRADUATED	MAJOR	DEGREE AWARDED
HIGH SCHOOL _____ NAME: _____ ADDRESS: _____ CITY AND STATE: _____ TO/FROM: _____			
COLLEGE NAME: _____ ADDRESS: _____ CITY AND STATE: _____ TO/FROM: _____			
POST GRADUATE NAME: _____ ADDRESS: _____ CITY AND STATE: _____ TO/FROM: _____			
CHIROPRACTIC COLLEGE NAME: _____ ADDRESS: _____ CITY AND STATE: _____ TO/FROM: _____ DATE OF MATRICULATION: _____			

Have you ever been licensed or certified in another State or jurisdiction? YES ☐ NO ☐

Please complete the following:

STATE/JURISDICTION	LICENSE # AND TYPE LICENSE	DATE OF INITIAL LICENSURE	DATE OF EXPIRATION

Please list the State/Jurisdiction in which you took the NBCE national examination, the date you passed the examination, and your score?

<b>PARTS</b>	State/Jurisdiction	Date Passed <i>(all sections)</i>
Part I		
Part II		
Part III		
Part IV		

Check appropriate response to the questions. Any **YES** response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

**HAVE YOU EVER:**

1. Had any state or territory of the U.S., province/territory of Canada, or any other jurisdiction EVER deny your application for any type of examination, professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? YES ☐ NO ☐

2. Been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your DEA Registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances?

YES ☐ NO ☐ N/A ☐

3. Received a sanction from Medicare or from a state Medicaid program?

YES ☐ NO ☐

4. Suffered from any psychiatric or addictive disorder that would impair or require limitations on your functioning as a practitioner or resulted in an inability to engage in your professional practice for more than 30 days?

YES ☐ NO ☐

5. Been indicted, arrested or convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)?

YES ☐ NO ☐

(If YES, please attach a detailed explanation and provide a copy of the court judgment/disposition.)

6. Had hospital or similar health care institution privileges which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?

YES ☐ NO ☐ N/A ☐

7. Had a claim or suit alleging malpractice liability, a claim settlement by a negotiation/arbitration or judgment by a court in a claim of medical malpractice liability in which you are/were named as a defendant with any degree of liability including "nuisance" suits and including settlements made by your insurance company/representatives without your express consent?

YES ☐ NO ☐

8. Applied for hospital or similar health care institution privileges, which were denied?

YES ☐ NO ☐

9. Do you intend to practice chiropractic within the State of Maine at a Maine hospital?

YES ☐ NO ☐

Applicant's Name (Please Print)	
Applicant's Contact Address	Street
	City/State/Zip
	Telephone #

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_



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ANNE L. HEAD  
DIRECTOR

**VERIFICATION OF LICENSURE**

This form must be completed by the State Licensure Board and must be sent to the Office together with your application and other supporting documents. Do not complete any part of this form except as noted below.

**This document will NOT be accepted if it is a copy, defaced or altered, or not accurately completed in full.**

➔ **THIS SECTION TO BE COMPLETED BY THE APPLICANT – Print Legibly**

<b>Full Name</b> (Print Legibly)		
<b>Contact Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Signature</b>		

➔ **THIS SECTION TO BE COMPLETED BY THE STATE LICENSING BOARD OR JURISDICTION ONLY**

I, the above named, am applying for a Chiropractor license in the State of Maine. Verification of my license and its status from each state that I hold or have held a Chiropractor license is required. I hereby request and authorize the release of any information in your files, favorable or otherwise as requested below.

<b>Type License Held:</b> <input type="checkbox"/> <b>Chiropractor</b> <input type="checkbox"/> <b>Other</b> _____		
<b>License Number</b>	<b>Expiration Date</b>	<b>First Issue Date</b>
<b>By which process was this license granted?</b>	<input type="checkbox"/> <b>By</b> Endorsement <input type="checkbox"/> <b>By</b> Exam <input type="checkbox"/> <b>Other</b> , please describe. _____	
Has your state or territory of the U.S. ,province/territory of Canada EVER denied this person's application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> If yes, please attach a copy of any board order issued or consent agreement, or a separate letter with details.		
Are there any complaints against the applicant? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> We can neither confirm nor deny the existence of a complaint. If yes, please explain.		
AFFIX STATE SEAL HERE	State/Jurisdictional Official Completing this Form <i>(Please Print)</i>	
	State completing this form	
	Signature and Title of State Official	Date

## CERTIFICATE OF MORAL CHARACTER

*This form must be completed by the person attesting to the applicant's good moral character.*

The person attesting to the applicant's good moral character must be personally known to him/her and be prepared to furnish additional information concerning the applicant's character, education, and standing as may be requested by the Board of Chiropractic Licensure.

I, the undersigned, hereby confer that I am personally acquainted with the applicant named below and know him/her to be of good moral character.

*Please write legibly*

Applicant's Name (Please Print)	
Name of Person Conferring Applicant's Character	Name
	Street
	City/State/Zip
	Telephone #
	(H) (W)
	Signature
	Date
Briefly describe how the applicant is known to you. (e.g. fellow colleague, neighbor, long time friend, etc.)	



JOHN ELIAS BALDACCI  
GOVERNOR

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**AUTHORIZATION OF CREDIT CARD PAYMENT**

**Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.**

Name of applicant:		
Contact address of applicant:		
City:	State:	Zip Code:
County:	Telephone #: (____)____-____	
Name of cardholder (if other than applicant):		
Contact address (if other than applicant):		
City:	State:	Zip Code:
I authorize the State of Maine, Department of Professional & Financial Regulation, Office of Licensing & Registration to charge my <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard _____ Card Number		
Exp Date ____/____ in the amount of \$ _____		
Signature: _____ Date: _____		